Iowa Medicaid Enterprise
Dental Claim Form Instructions
2006 ADA Dental Claim Form

These are the revised and updated instructions for the 2006 ADA Dental Claim Form. The instructions are organized by field number, field name/description, whether or not that field is required, and a brief description of the information that needs to be entered in that field, and how it needs to be entered.

Major changes include:

- **NPI ONLY WILL BE ACCEPTED ON CLAIMS. ALL OTHER PROVIDER IDENTIFIERS INCLUDING BUT NOT LIMITED TO LEGACY AND UPIN NUMBERS ARE NO LONGER ACCEPTED.**
- Field 49. The Billing NPI is **REQUIRED**.
- Field 52A. This field **MUST be BLANK**. Entering information in this field will cause the claim to be returned.
- Field 54. The Rendering/Treating NPI is **REQUIRED** if applicable.
- Field 56A. The Taxonomy Code associated with the Billing NPI is **REQUIRED.**
- Field 58. This field **MUST be BLANK**. Entering information in this field will cause the claim to be returned.

Note: If a claim is submitted with any legacy numbers, the **claim will be returned**.

If you have any questions about this information, please contact Provider Services at 1-(800)-338-7909. (Local in the Des Moines area at (515)-725-1004)

FIELD NO.	FIELD NAME/DESCRIPTION	REQUIREMENTS	INSTRUCTIONS
1.	Type of Transaction	**REQUIRED**	Check "Statement of Actual Services" if the statement is for actual services. Check "EPSDT/Title XIX" if the services are a result of a referral from an EPSDT *Care for Kids* screening examination. **Note:** Requests for predetermination/preauthorization should be completed using the prior authorization form.
2.	Predetermination/ Preauthorization Number	*SITUATIONAL*	**REQUIRED** if Medicaid has assigned a predetermination/Prior authorization number for the services. Enter the prior authorization number for the services.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION			
3.	Company/Plan Name, Address, City, State, Zip Code	OPTIONAL	No entry required.

OTHER COVERAGE			
4.	Other Dental or Medical Coverage?	**REQUIRED**	Check "NO" if the member does not have other medical or dental insurance. Check "YES" if the member has other insurance and payment was received from the other insurance. (Indicate amount in #32.) Check **both** "NO" and "YES" if the member has other insurance **and** you have received a **denial** from that insurance. **Note:** Medicaid should be billed **only after** the other insurance plans have been billed. If "YES", or if both "NO" and "YES" are checked, **#5-11 must be completed**.
5.	Name of Policyholder/ Subscriber in #4	*SITUATIONAL*	REQUIRED if the patient has other insurance. Enter the last name, first name, and middle initial of the primary subscriber.
6.	Date of Birth	*SITUATIONAL*	REQUIRED if the patient has other insurance. Enter the date of birth of the primary subscriber. Entry should be made in MM/DD/YYYY format.
7.	Gender	*SITUATIONAL*	REQUIRED if the patient has other insurance. Check the appropriate box for the primary subscriber's gender.
8.	Policyholder/ Subscriber ID	*SITUATIONAL*	REQUIRED if the patient has other insurance. Enter the other insurance ID# or the SSN of the primary subscriber.
9.	Plan/Group Number	*SITUATIONAL*	REQUIRED if the patient has other insurance. Enter the plan/group number for the other insurance of the primary subscriber.
10.	Patient's Relationship to Person Named in # 5	*SITUATIONAL*	REQUIRED if the patient has other insurance. Check the appropriate box to reflect the relationship the Patient has with the policyholder named in #5.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	*SITUATIONAL*	REQUIRED if the patient has other insurance. Enter the name, address, city, state, and zip code of the other insurance company/dental benefit plan.
POLICYHOLDER/SUBSCRIBER INFORMATION			
12.	Policyholder/Subscriber Name, Address, City, State, Zip Code	**REQUIRED**	Enter last name, first name, and middle initial of the Medicaid member. Use the *Medical Assistance Eligibility Card* for verification.
13.	Date of Birth	**REQUIRED**	Enter the date of birth if the member. Entry should be made in MM/DD/YYYY format.
14.	Gender	**REQUIRED**	Check the appropriate box for the member's gender.
15.	Policyholder/ Subscriber ID	**REQUIRED**	Enter the Medicaid identification number of the member. This number consists of seven numbers and a letter, i.e. 1234567A. This number can be found on the *Medical Assistance Eligibility Card.*
16.	Plan/Group Number	OPTIONAL	No entry required.
17.	Employer Name	OPTIONAL	No entry required.

PATIENT INFORMATION			
18.	Relationship to Policyholder/Subscriber in #12	OPTIONAL	No entry required.
19.	Student Status	OPTIONAL	No entry required.
20.	Name, Address, City, State, Zip Code	OPTIONAL	No entry required.
21.	Date of Birth	OPTIONAL	No entry required.
22.	Gender	OPTIONAL	No entry required.
23.	Patient ID/ Account #	OPTIONAL	Enter the number assigned by the Dentist's office relating to the patient's account or the record number. This field is limited to 20 characters.
RECORD OF SERVICES PROVIDED (For Insurance Company Named in #3)			
24.	Procedure Date	**REQUIRED**	Enter the date of service. Entry should be made in MM/DD/YYYY format. **Note:** One entry is required for each line billed.
25.	Area of Oral Cavity	*SITUATIONAL*	Report the area of the oral cavity unless one of the following conditions in #29 (procedure code) exists: a. The procedure identified in #29 requires the identification of a tooth or a range of teeth. b. The procedure identified in #29 incorporates a specific area of the oral cavity (for example: D5110 complete denture – maxillary). c. The procedure identified in #29 does not relate to any portion of the oral cavity (for example: D9220 deep sedation/general anesthesia – first 30 minutes). **Note:** *The ANSI/ADA/ISO Specification No. 3950 – 1984 Dentistry Designation System for Teeth and Areas of the Oral Cavity* should be used in reporting the area of oral cavity. Valid entries are: 00 Whole of the oral cavity 01 Maxillary area 02 Mandibular area 10 Upper Right quadrant 20 Upper Left quadrant 30 Lower Left quadrant 40 Lower Right quadrant
26.	Tooth System	OPTIONAL	No entry required.
27.	Tooth Number(s) or Letter(s)	*SITUATIONAL*	When billing an applicable procedure code: Enter the tooth number (permanent teeth) or tooth letter (deciduous teeth). **Note:** *The ADA's Universal/National Tooth Designation System* is to be used in reporting tooth number/letter. If the same procedure is performed on more than one tooth, on the same date of service, report each procedure and tooth designation on **separate lines** on the claim form.

28.	Tooth Surface	*SITUATIONAL*	When billing an applicable procedure code: Enter the standard ADA designation of the tooth Surfaces.
29.	Procedure Code	**REQUIRED**	Enter the appropriate procedure code found in the version of the *code on dental procedures and Nomenclature* in effect on the "procedure date" (#24).
30.	Description	*SITUATIONAL*	REQUIRED When more than one service is being billed. Enter, in parenthesis, the number of units being billed for the line (e.g., (2 units)).
31.	Fee	**REQUIRED**	Enter the **usual** and **customary** charge for each line item billed. **Note:** The total **must** include **both** dollars and cents. **DO NOT** enter the fee from the Medicaid fee schedule.
32.	Other Fee(s)	*SITUATIONAL*	REQUIRED if the member has other insurance **and** the insurance has made a payment on the claim. Enter the payment amount received from other insurance in relation to the claim. **DO NOT** include the member's co-payment amount in this box. **Note:** The total **must** include **both** dollars and cents.
33.	Total Fee	**REQUIRED**	Enter the sum of the charges listed in #31 (Fee). This field should be completed on the last page of the claim **only**. **Note:** **DO NOT** subtract any amounts paid by other insurance.
MISSING TEETH INFORMATION			
34.	(Place an "X" on each missing tooth)	*SITUATIONAL*	Place an "X" on the missing tooth letter/number. **Note:** *The ADA's Universal/National Tooth Designation System* is used to name teeth on the form.

35.	Remarks	*SITUATIONAL*	Enter the word "Pregnant", if the patient was pregnant when the services were performed. Failure to indicate that the member was pregnant at the time of service may result in incorrect payment. Enter the reason for replacement if crowns, partial or complete dentures are being replaced. Enter a brief description if treatment is the result of an occupational illness/injury, auto accident, or other accident. **Note:** This space may be used to convey additional information for a procedure code that requires a report, or for multiple supernumerary teeth. It can also be used to convey additional information believed necessary to process the claim. Remarks should be concise and pertinent to the claim submission.
AUTHORIZATIONS			
36.	Patient/Guardian signature	OPTIONAL	No entry required.
37.	Subscriber signature	OPTIONAL	No entry required.
ANCILLARY CLAIM/TREATMENT INFORMATION			
38.	Place of Treatment	**REQUIRED**	Check the applicable box. **Note:** If no box is marked, the claim will process as if the services were performed in the office, and may result in incorrect payment.
39.	Number of Enclosures	**REQUIRED**	Enter the number of enclosures. This **item is completed regardless** if radiographs, oral images, or study models that are submitted with the claim. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent. When supplementary material is sent with the claim, the number of each type is entered in the appropriate box using two digits. If less than 10, use 0 in the first position. "Oral Images" include digital radiographic images and are reported by the number of images.
40.	Is Treatment for Orthodontics?	OPTIONAL	No entry required.
41.	Date Appliance Placed	OPTIONAL	No entry required.
42.	Months of Treatment Remaining	OPTIONAL	No entry required.

43.	Replacement of Prosthesis?	*SITUATIONAL*	REQUIRED when billing for crowns, partial, or complete dentures. Check the applicable box. If "YES" is checked, then indicate the reason for replacement under "Remarks" in #35.
44.	Date Prior Placement	*SITUATIONAL*	REQUIRED if "YES" is checked in #43, **and** if prior placement is less than 5 years ago. Enter the date of prior placement. Entry should be made in MM/DD/YYYY format.
45.	Treatment Resulting from	*SITUATIONAL*	REQUIRED ONLY if treatment is result of occupational illness or injury, auto accident, or other accident. Check the applicable box and enter a brief description in #35.
46.	Date of Accident	*SITUATIONAL*	REQUIRED ONLY if treatment is result of occupational illness or injury, auto accident, or other accident. Enter the date of the accident. Entry should be made in MM/DD/YYYY format.
47.	Auto Accident State	*SITUATIONAL*	REQUIRED ONLY if treatment is result of occupational illness or injury, auto accident, or other accident. Enter the two letter postal state code for the state in which the auto accident occurred.
BILLING DENTIST OR DENTAL ENTITY			
48.	Name, Address, City, State, Zip Code	**REQUIRED**	Enter the name and complete address of the Dentist or the dental entity (Corporation, group, etc.). **Note:** The address **must** contain the zip code associated with the billing dentist/dental entity's NPI. The zip code **must** match the zip code confirmed during NPI verification. To view the confirmed zip code visit imeservices.org
49.	NPI *	**REQUIRED**	Enter the NPI of the billing entity.
50.	License Number	OPTIONAL	No entry required.
51.	SSN or TIN	OPTIONAL	No entry required.
52.	Phone Number	OPTIONAL	No entry required.
52A.	Additional Provider ID *	**LEAVE BLANK**	This field must left BLANK. The claim will be returned if information is submitted in this field.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION			
53.	Treating Dentist signature	**REQUIRED**	Enter the name of the treating Dentist and the date the form is signed.
54.	NPI *	**REQUIRED**	Enter the NPI of the treating Dentist.
55.	License Number	**REQUIRED**	Enter the license number of the treating Dentist.
56.	Address, City, State, Zip Code	**REQUIRED**	Enter the complete address of the treating Dentist. **Note:** The address **must** contain the zip code associated with the treating Provider's NPI. The zip code **must** match the zip code confirmed during NPI verification. To view the confirmed zip code visit imeservices.org

56A.	Provider Specialty Code *	**REQUIRED**	Enter the taxonomy code associated with the **billing entity's NPI.** **Note:** The taxonomy code **must** match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code visit imeservices.org
57.	Phone Number	OPTIONAL	No entry required.
58.	Additional Provider ID *	**LEAVE BLANK**	This field must left BLANK. The claim will be returned if information is submitted in this field.